Noncommunicable diseases

Regional framework for action

Despite declared political commitment to implement the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases, many countries are experiencing challenges in moving to concrete action. The response to the 2011 UN political declaration and to the regional framework for action which was endorsed by the Regional Committee in 2012 has been patchy and uneven. Factors responsible for this situation vary from one country to another but generally include inadequate political commitment at the highest level, competing priorities particularly in crisis-stricken countries, weak engagement of non-health sectors whose action is essential in the implementation of key measures, weak health systems including fragmented health information systems, opposing forces including the tobacco industry and the unopposed marketing of unhealthy foods, and the absence of an effective civil society movement.

In 2015, focus continued to be placed on scaling up the implementation of the regional framework for action. Since its endorsement by the Regional Committee, in 2012, the framework has been updated annually and a set of process indicators, intended to guide Member States in measuring progress in implementing the strategic interventions, has been developed.

We continued to hold annual regional meetings on noncommunicable diseases to provide an opportunity for Member States to review the progress made with international and regional experts and to respond to their needs for technical support. In addition the Regional Office continued in 2015 and 2016 to develop concrete technical guidance that will enable countries to implement measures recommended in the four areas of the regional framework (governance, surveillance, prevention and health care) based on evidence, international experience and best practice.

Framework for action to implement the United Nations Political Declaration on Noncommunicable Diseases, including indicators to assess country progress by 2018

Framework for action to implement the United Nations political declaration on noncommunicable diseases

Governance

High-level advocacy was carried out throughout 2015 at various forums, including the World Health Assembly and the Regional Committee, to promote collaboration across sectors outside health and between government and non-state actors. Only six countries now have an operational multisectoral strategy and/or action plan, and four have set targets for 2025 based on WHO guidance. Countries of the Region are at various stages of implementation of their action plans and WHO continues to monitor the situation in collaboration with them, based on the process indicators of the regional framework.

↑ *Technical guidance on tobacco control*

An innovative initiative was the development, in collaboration with the WHO Collaborating Centre at Georgetown University, of a dashboard and policy briefs on best practices in health legislation, based on global evidence. The work provides a guide for countries to take appropriate legislative action to tackle key risk factors in the areas of tobacco control, diet, physical activity and governance. Each of the priority interventions identified is outlined through an individual legal brief that contains tangible recommendations applicable to countries, drawing from global, regional and national experiences, and adaptable to the local economic, social and legal context.

Prevention and control of risk factors

Industry interference with tobacco control policies and the limited involvement of non-health actors continue to be major challenges to operationalizing the interventions in the area of prevention and control of risk factors for noncommunicable diseases. Sixteen countries have adopted a national level target for reducing tobacco use by 30% by 2025 and 17 countries are in the process of implementing taxation increases based on the guidelines to Article 6 of the WHO Framework Convention on Tobacco Control (WHO FCTC). Support was also provided to countries for updating tobacco control legislation, specifically on the aspects of tobacco-free public places, pictorial health warnings, and banning of advertising, promotion and sponsorship.

One of the main activities undertaken was the raising of political awareness on tobacco control issues, particularly on the WHO FCTC protocol and the industry's influence on tobacco advertising, promotion and sponsorship in drama (TAPS). In this context, six projects were funded for implementation by nongovernmental organizations and completed, tackling different aspects of tobacco use in dramas aired on the

regional language networks. Two countries (Yemen and United Arab Emirates) were cited in the *WHO Report on the Global Tobacco Epidemic, 2015* as among the highest achieving countries in terms of banning TAPS, and Saudi Arabia was cited as one of the countries that had achieved full compliance with banning tobacco use in public places. Technical support was provided for capacity-building on smoking cessation and ratification of the WHO FCTC protocol in the Gulf Cooperation Council (GCC) countries. Saudi Arabia and Iraq became parties to the WHO FCTC protocol and three new countries joined the highest achieving countries in terms of monitoring (Kuwait, Pakistan and Qatar).

The burden of overweight, obesity and diet-related chronic diseases continues to increase due to nutrition transition, especially in high-income and middle-income countries. Seventeen countries have adopted the International Code of Marketing of Breast-milk Substitutes, and are monitoring its application. Nevertheless the progress on implementation is uneven. A number of policy guidance documents were developed to support the adoption of sustainable multisectoral approaches. These included policy statements and recommended actions for reducing salt, fat and sugar intakes and a protocol for measuring salt intake using 24 hour-urine collection.

Current salt intakes in the Region are very high, with an average intake of 10 g per person per day in most countries. Implementation of salt reduction strategies is progressing in several countries, and multisectoral national committees have been established in some countries with an authority to strategize and monitor implementation of salt reduction activities. Intake estimates for saturated fatty acids are also high, with most countries exceeding the 10% upper limit. Initiatives

البيان الخاص بالسياسات والإجراءات الموصى بها لخفض مدخول السكر والحد من معدلات انتشار الإصابة بالسكري من النمط 2 والسمنة في إقليم شرق المتوسط

Déclaration de principe et mesures recommandées aux fins de la diminution des apports en sucre et de la réduction de la prévalence du diabète de type 2 et de l'obésité dans la Région de la Méditerranée orientale

Policy statement and recommended actions for lowering sugar intake and reducing prevalence of type 2 diabetes and obesity in the Eastern Mediterranean Region

Policy goal

Lower sugar intake and reduced prevalence of type 2 diabetes and obesity, in order to reduce the risk of noncommunicable diseases in children and adults, with a particular focus on the prevention of unhealthy weight gain and associated conditions, such as diabetes and dental caries.

Rationale

The policy is based on the WHO guidelines specifying that all individuals – children and adults – should consume less than 10%, or preferably 5%, of free sugars in their diet[1]. Given the extraordinarily high rates of obesity and diabetes in the Region, 5% is seen as the most appropriate long-term goal. Free sugars include mono-saccharides and disaccharides added to foods and beverages by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, fruit juices and fruit juice concentrates. This will require a major change in food intake patterns and the proposed new low sugar goal of 5% will, realistically, require radical new policies as intakes are known to be far higher than 5% in most, if not all, countries of the Region.

Policy-makers and programme managers are now advised to assess current free sugar intake levels and their sources in both foods and drinks and consider how to develop nationwide measures that result in a transformation of the food chain in their country.

Governments should consider introducing a progressive and sustainable reduction in national sugar intake over the next 3–4 years. Substantial falls, e.g. of 50% or more in sugar intake, are now considered necessary to halt the rise in diabetes and obesity and reduce the burden of premature deaths due to noncommunicable diseases by 25% by 2025.

A more detailed analysis of why sugar leads to weight gain with all its complications of diabetes, heart disease and cancers, as well as the additional risk of diabetes independent of weight gain and major dental problems, such as tooth loss and dental infections in all age groups, and poor childhood growth, is summarized in Annex 1. However, given that the Region has the highest prevalence of diabetes in the world it is relevant that new systematic analyses estimate that an extra soft drink a day increases the risk of diabetes by nearly a fifth (18%)[2]. Obesity rates are also extraordinarily high in both children

[1] Guideline: sugars intake for adults and children. Geneva: World Health Organization; 2015 (http://www.who.int/nutrition/publications/guidelines/sugars_intake/en/, accessed 22 March 2016).

[2] Imamura F, et al. Consumption of sugar sweetened beverages, artificially sweetened beverages, and fruit juice and incidence of type 2 diabetes: systematic review, meta-analysis, and estimation of population attributable fraction. BMJ. 2015;351:h3576.

World Health Organization
Regional Office for the Eastern Mediterranean

↑ ***Policy statement and recommended actions on lowering sugar intake***

aimed at reducing total and saturated fat in food products have been undertaken in several countries (Egypt, Iraq, Islamic Republic of Iran and GCC countries). In most countries, industry participation remains voluntary and timid. Food labelling for total fat, saturated fatty acids, *trans*fat and salt in all food imported or locally produced became mandatory in GCC countries. In Egypt, the first steps were taken to reduce palm oil intake with the circulation of a draft standard on subsidized cooking oil. In several countries, private industry moved towards voluntary production of low fat and fat-free dairy products.

A draft nutrient profiling model was developed to guide countries in categorizing foods and beverages into 'healthy' and 'unhealthy'. Support was provided, in collaboration with the WHO Regional Office for Europe, WHO headquarters and Liverpool University, to several countries to develop a provisional roadmap to speed up action on marketing of unhealthy foods through building capacity for legal interventions. A

series of sensitization activities culminated in an open forum attended by mainstream media outlets, regional celebrities, media experts and representatives of civil society organizations which resulted in recommendations for non-health sectors to address marketing of unhealthy foods to children.

In order to promote physical activity, capacity development was supported in mass media and social marketing, in partnership with the WHO Collaborating Centre on Physical Activity, Nutrition and Obesity, Sydney, Australia. The first round, in which nine countries participated, resulted in development by representatives of both health and non-health sectors of provisional social marketing and mass media plans. Distance mentoring on implementation was started with four countries (Islamic Republic of Iran, Kuwait, Oman and Morocco). In addition, a toolkit was developed to guide inclusion of physical activity in primary health care.

Surveillance, monitoring and evaluation

The key priority is for Member States to implement the NCD surveillance framework with its three components (monitoring risk factors and determinants, tracking morbidity and premature cause-specific mortality, and assessing health system response and performance). The indicators included under each of the three components will enable Member States to monitor their progress in achieving the targets of the global action plan endorsed by the World Health Assembly.. A training module has been developed and will be offered to countries to build capacity in NCD surveillance and a training course for trainers is expected to be conducted before the end of 2016.

A number of surveys were completed as part of monitoring risk factors. Almost all countries completed the 2015 country capacity survey for noncommunicable diseases, and several countries are engaged at various stages of the STEPS survey to monitor the burden and trends of risk factors, the Global Adult Tobacco Survey and the Global Youth Tobacco Survey. Capacity-building in cancer surveillance was conducted in collaboration with the International Agency for Research on Cancer (IARC), with a focus on establishing population-based cancer registries in countries, while a regional course to further strengthen capacity in surveillance was piloted and is being revised. This was further supported by setting up a standardized assessment tool to identify obstacles and opportunities for countries to scale up surveillance.

Health care

The reorientation of health systems towards the integration of management of noncommunicable diseases into primary health care is a key priority. Building on the recommendations of a regional meeting held in 2014, a guide was developed for assessment of the health systems components underlying effective integration. In addition, a review of global evidence was conducted to support the development of a matrix of policy options, based on WHO health systems building blocks and tailored according to country needs. A core set of quality indicators for management of noncommunicable diseases was developed, as part of a regional initiative on quality measures in primary health care.

A regional situation analysis of care of noncommunicable diseases in emergencies was conducted in five countries focusing on refugees and displaced persons from the Syrian Arab

Republic. The findings of the analysis emphasized the importance of a consistent primary health care approach to provision of care, even in emergency contexts. Experiences in the Region have also revealed the need for a standardized set, and timely provision, of core essential medicines and technologies. An emergency health kit for management of noncommunicable diseases was therefore developed, complementing the Interagency Emergency Health Kit.

Country profiles were developed showing where each country stands in addressing the five strategic areas of cancer prevention and control. Work focused on building capacity, first, in establishing or assessing cancer registries, and second, in the development of palliative care. Many countries have invested substantially in organizing nationwide breast cancer screening and public health awareness campaigns. In 2015 WHO provided technical support for the development of screening programmes and for evaluation of public awareness campaigns.

In 2015 the Regional Office led, and played an important role in, advocacy for an accountability framework to measure progress. The contribution of countries was substantial in ensuring that the 10 indicators crafted to measure progress were aligned with the indicators of the regional framework for action. Countries are now better able to monitor and report on progress, and to meet their commitment in implementing the time-bound commitments of Member States: by 2015, to set national targets, and develop/strengthen national multisectoral action plans; and by 2016, to reduce risk factors, and strengthen health systems.

WHO will continue to work with Member States to accelerate progress, which will be measured by the progress indicators during the next United Nations review in 2018. Focus will be placed on raising political awareness and increasing the level of multisectoral involvement in implementing the provisions of the regional framework through a whole-of-government approach and on providing technical support to countries.

Mental health

Mental, neurological and substance disorders account for the loss of 7.4% of disability-adjusted life-years, and for 22.9% of the years lived with disability globally. Illicit drug use accounts for 0·9% of DALYs lost globally. The age-standardized prevalence of drug dependence for cannabis (0.19%), amphetamines (0.25%), cocaine (0.10%) and opioids (0.22%) in the Region are similar to global estimates. However, the Region has the highest prevalence of mental disorders, specifically depressive illness and anxiety disorders, of all WHO regions. This is almost wholly accounted for by the complex emergency situations prevailing within the Region. While all countries have made some progress, irrespective of national income level, a huge treatment gap remains, ranging from 76% to 85% for severe mental disorders.

Despite the great burden, mental health continues to have a low political and public health profile while the stigma attached to it cuts across all aspects of mental health care, with widespread discrimination that has major impact on service development, delivery and utilization. Mental health has suffered chronic under-funding and consequently there is a paucity of specialist staff and services. The skills of both general health workers and mental health leaders are largely limited to the delivery of care.

Institutional care is still the dominant model of care in the majority of countries. This constrains the capacity for development of mental health staff and has led to human rights abuses. There is a lack of research evidence and information from within the Region to underpin strategic planning and service development. Nevertheless, mental health and substance abuse are starting to attract more attention, both globally and regionally, and the number of countries experiencing complex emergency situations is driving up the need and demand for support services.

In 2015, the Regional Committee endorsed an evidence-based regional framework which was developed between 2014 and 2015 by the Regional Office in consultation with Member States and top international and regional experts. The aim of the framework is to scale up action on mental health and operationalize the *Comprehensive mental health action plan 2013–2020*. Four domains of action were identified by the regional framework: governance, prevention, health care and surveillance.

Good progress has been made by some countries. In the area of governance, some countries (Kuwait, Lebanon, Oman, Qatar, Somalia, United Arab Emirates) developed or updated their mental health strategies in accordance with the global targets and indicators. Three countries (Afghanistan, Saudi Arabia and United Arab Emirates) reviewed their mental health legislation and regulations in accordance with provisions of the United Nations Convention for the Rights of Persons with Disabilities (UNCRPD). The curriculum for a regional course in leadership in mental health was developed and the first course was hosted by American University in Cairo (AUC) in September 2015.

Cadre régional pour intensifier l'action en matière de santé mentale dans la Région de la Méditerranée orientale

الإطار الإقليمي لتوسيع نطاق العمل في مجال رعاية الصحة النفسية في إقليم شرق المتوسط

Regional framework to scale up action on mental health in the Eastern Mediterranean Region

World Health Organization
Regional Office for the Eastern Mediterranean

Domain	Strategic interventions	Proposed indicators
Governance	Establish/update a multisectoral national policy/strategic action plan for mental health	Country has an operational multisectoral national mental health policy/plan in line with international/regional human rights instruments
	Embed mental health and psychosocial support in national emergency preparedness and recovery plans	Mental health and psychosocial support provision is integrated in the national emergency preparedness plans
	Review legislation related to mental health in line with international human rights covenants/ instruments	Country has updated mental health legislation in line with international/regional human rights instruments
	Integrate priority mental conditions in the basic health delivery package of the government and social/private insurance reimbursement schemes	Inclusion of specified priority mental health conditions in basic packages of health care of public and private insurance/reimbursement schemes
		Enhanced budgetary allocations are in place for addressing the agreed upon national mental health service delivery targets
Health care	Establish mental health services in general hospitals for outpatient and short-stay inpatient care	Proportion of general hospitals which have mental health units, including inpatient and outpatient units
	Integrate delivery of cost-effective, feasible and affordable evidence-based interventions for mental conditions in primary health care and other priority health programmes	Proportion of persons with mental health conditions utilizing health services (disaggregated by age, sex, diagnosis and setting)
	Provide people with mental health conditions and their families with access to self-help and community-based interventions.	Proportion of primary health care facilities with regular availability of essential psychotropic medicines
	Downsize the existing long-stay mental hospitals	Proportion of primary health care facilities with at least one staff trained to deliver non-pharmacological interventions
		Proportion of mental health facilities monitored annually to ensure protection of human rights of persons with mental conditions using quality and rights standards
	Implement best practices for mental health and psychosocial support in emergencies	Proportion of health care workers trained in recognition and management of priority mental conditions during emergencies
Promotion and prevention	Provide cost-effective, feasible and affordable preventive interventions through community and population-based platforms	Proportion of schools implementing the whole-school approach to promote life skills
		Proportion of mother and child health care personnel trained in providing early childhood care and development and parenting skills to mothers and families
	Train emergency responders to provide psychological first aid	Proportion of mother and child health care personnel trained in early recognition and management of maternal depression
		Availability of operational national suicide prevention action plan
		Regular national campaigns to improve mental health literacy and reduce stigma using multiple delivery channels
		Psychological first aid (PFA) training is incorporated in all emergency responder trainings at national level
Surveillance, monitoring and research	Integrate the core indicators within the national health information systems	Routine data and reports at national level available on the core set of mental health indicators
	Enhance the national capacity to undertake prioritized research	Annual reporting of national data on numbers of deaths by suicide

↑ ***Regional framework to scale up action on mental health***

In the area of health care, support was provided in a number of areas. More than half the countries now have functioning mhGAP programmes aimed at bridging the treatment gap for priority mental health problems through integration within primary health care. So far three countries (Afghanistan, Jordan, Libya) have initiated the Quality and Rights project based on the provisions of the UNCRPD to ensure quality of services and observance of patient's rights in psychiatric facilities. Services for substance use disorders were strengthened in Iraq and Pakistan through capacity-building and support for the setting up of centres, in collaboration with the United Nations Office on Drugs and Crime (UNODC). Opium substitution treatment services were established in Pakistan and expanded in other countries, while a harm reduction protocol was developed in Oman.

Support was provided, in collaboration with WHO headquarters and international nongovernmental organizations, to countries undergoing humanitarian crises in mental health and psychosocial support in emergencies,

through strengthening the technical capacities of the country offices, as well as direct support. The Arabic version of a training package for psychological first aid was published, and a psychosocial intervention package to be delivered through non-specialized health workers in emergencies is being field-tested.

In the area of prevention, the Arabic version of the global report on suicide was published and launched in 2014. An assessment of resources and capacities available for diagnosis and management of autism spectrum disorders was conducted in collaboration with the Italian Public health Institute and the organization Autism Speaks. A training package on mental health for schools was finalized and is in the process of piloting in selected countries, while life skills education materials and parenting skills training materials for autism spectrum disorders are also being finalized.

Guidance was published on setting up systems for suicide registration and substance use treatment information. A core set of quality indicators for mental health care in primary health care was developed, as part of a regional initiative on primary health care quality measures.

WHO will strengthen its linkages and collaboration with regional and global partners to implement the provisions of the regional framework for action in the Region and operationalize the provisions of the global action plan 2013–2020. It will enhance its ability to provide support to countries for reviewing and developing national policies and strategies in line with the global action plan and focus on enhancing the specialist and non-specialist workforce for the integrated delivery of quality mental health care. It will also lead the development of a mental health literacy package and campaign to combat the stigma attached to mental health and substance abuse. It will continue to support countries to scale up mental health and psychosocial support in emergencies and will also promote mental health through school mental health, suicide prevention and mental health literacy programmes.